

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00773

0780

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN life 37 Chestertown, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 224 Kent St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First L Middle Edna Last Barnett		4. DATE OF DEATH Jan. 5, 1960 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Sheats		14. MOTHER'S MAIDEN NAME Margaret Rasin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Miss Lucie Frazier		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 416 X DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO Old rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-12 , 19 59 , to Jan. 5 , 19 60 , that I last saw the deceased alive on Jan. 5 , 19 60 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. C. Dick		DATE SIGNED 1-6-60	
PHYSICIAN'S NAME (Type) A. C. Dick		ADDRESS (Street, city or town, state) Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/60	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Ches tertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells		ADDRESS Chest ertown, Md.	
24a. REC'D BY REGISTRAR DAN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00780

0788

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ident</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Ident</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Merrington</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Susan Cannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Blanch Hepburn</u>		Address <u>Rock Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Gatewood</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, Md</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM GATEWOOD</u>		DATE SIGNED <u>1/9/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-11-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall</u> <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 13 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinas</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1900	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
NEW YORK		JAN 1 1855		NEW YORK		JAN 15 1900		10:30 AM	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO	
PREVIOUS DISEASES		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENTS		PREVIOUS DRUGS	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		CITY		COUNTY	
JAN 15 1900		10:30 AM		NEW YORK		NEW YORK		NEW YORK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0781

CERTIFICATE OF DEATH

Reg. Dist. No.

00781

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN life 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Co. Hosp.		d. STREET ADDRESS /Washington Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ann Middle Russell Last Culp		4. DATE OF DEATH Month Jan. Day 25 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Kent CO. Md.	
11. BIRTHPLACE (State or foreign country) Kent CO. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T. Waters Russell		14. MOTHER'S MAIDEN NAME Benanna Frazier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Naomi Russell		Address Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Arterio sclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) several yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe upper respiratory infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25 , 19 56 , to Jan. 25 , 19 60 , that I last saw the deceased alive on Jan. 25 , 19 60 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
DATE SIGNED Jan. 26, 1960			
PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/60	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR JAN 28 '60		24b. REGISTRAR'S SIGNATURE Gail S. Hume	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. WILSON		Male		65		1880		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 Main St., Baltimore, Md.		Retired		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOURS		MINUTES		PLACE OF DEATH	
Jan 15, 1945		10:30 AM		10		30		Home	
DECEASED'S SIGNATURE		WITNESSES' SIGNATURES		DOCTOR'S SIGNATURE		REGISTRAR'S SIGNATURE		PLACE OF DEATH	
James H. Wilson		John Doe, John Smith		Dr. J. K. L.		Mr. A. B. C.		Home	
DECEASED'S ADDRESS		DECEASED'S OCCUPATION		DECEASED'S RELIGION		DECEASED'S RACE		DECEASED'S COLOR	
1234 Main St., Baltimore, Md.		Retired		Roman Catholic		White		White	
DECEASED'S MARITAL STATUS		DECEASED'S EDUCATION		DECEASED'S RELIGION		DECEASED'S RACE		DECEASED'S COLOR	
Married		High School		Roman Catholic		White		White	
DECEASED'S DATE OF MARRIAGE		DECEASED'S DATE OF BIRTH		DECEASED'S DATE OF DEATH		DECEASED'S DATE OF BURIAL		DECEASED'S DATE OF CREMATION	
Jan 1, 1910		1880		Jan 15, 1945		Jan 15, 1945		Jan 15, 1945	
DECEASED'S PLACE OF BIRTH		DECEASED'S PLACE OF DEATH		DECEASED'S PLACE OF BURIAL		DECEASED'S PLACE OF CREMATION		DECEASED'S PLACE OF INTERMENT	
Baltimore, Md.		Home		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery	
DECEASED'S PLACE OF INTERMENT		DECEASED'S PLACE OF CREMATION		DECEASED'S PLACE OF BURIAL		DECEASED'S PLACE OF INTERMENT		DECEASED'S PLACE OF CREMATION	
Catholic Cemetery		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery	
DECEASED'S PLACE OF CREMATION		DECEASED'S PLACE OF BURIAL		DECEASED'S PLACE OF INTERMENT		DECEASED'S PLACE OF CREMATION		DECEASED'S PLACE OF INTERMENT	
Catholic Cemetery		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery	
DECEASED'S PLACE OF INTERMENT		DECEASED'S PLACE OF CREMATION		DECEASED'S PLACE OF BURIAL		DECEASED'S PLACE OF INTERMENT		DECEASED'S PLACE OF CREMATION	
Catholic Cemetery		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> 0789 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Md (Rural)</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown (rural) Rt 2 - Life</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>				d. STREET ADDRESS <u>none</u>			
3. NAME OF DECEASED (Type or print) <u>WALTER BOWERS GREENWOOD</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>January 13, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Thomas Greenwood</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. BOWERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Carrie Sordage, Chestertown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable stroke or cerebral thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease 20 years</u> (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-31-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kennedy</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BALTIMORE 22
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for patient information, medical history, and examination findings. The form is oriented vertically on the page.

Handwritten text on the left side of the form, likely a patient identifier or case number, oriented vertically.

0782

CERTIFICATE OF DEATH

Reg. Dist. No.

00783

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>less than 1 day</u> 37 <u>Chestertown,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Ed Queen Anne's Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Wesley</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 January 1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George William Hall 2nd</u>		14. MOTHER'S MAIDEN NAME <u>Leonie Franklin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Premature delivery (at about 26 to 28 weeks)</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/3</u> , 19 <u>60</u> to <u>1/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/3</u> , 19 <u>60</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		CHESTERTOWN, Md. 1/3/60	
PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 5, 1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The purpose of this document is to provide information regarding the activities of the [redacted] organization.

2. The information contained herein is classified as [redacted] and is to be controlled accordingly.

3. It is the policy of the [redacted] to maintain the confidentiality of all information received from its sources.

4. This document is to be distributed only to those personnel who have been authorized to receive it.

5. The information contained herein is to be used for [redacted] purposes only.

6. It is the responsibility of the [redacted] to ensure that this information is not disclosed to unauthorized personnel.

7. The [redacted] is authorized to take such action as it deems necessary to protect the confidentiality of this information.

8. This document is to be destroyed when it is no longer required for [redacted] purposes.

9. The [redacted] is authorized to take such action as it deems necessary to protect the confidentiality of this information.

10. This document is to be destroyed when it is no longer required for [redacted] purposes.

11. The [redacted] is authorized to take such action as it deems necessary to protect the confidentiality of this information.

12. This document is to be destroyed when it is no longer required for [redacted] purposes.

13. The [redacted] is authorized to take such action as it deems necessary to protect the confidentiality of this information.

14. This document is to be destroyed when it is no longer required for [redacted] purposes.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00784

0790

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Butlertown RFD		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) First Florence Middle Hines Last Hines		4. DATE OF DEATH Month Jan. Day 28 Year 1960	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Hines		14. MOTHER'S MAIDEN NAME Annie Roomer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Elijah Smith		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 week 10 to 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia, right, right 7 or 8 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-6 1957 to 1-28 1960 , that I last saw the deceased alive on 1-28 1960 , and that death occurred at 5-PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1/30/60 DATE SIGNED			
ACTUAL SIGNATURE Robert W. Farr M.D.		CHESTERTOWN, MD.	
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.,		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/31/60	22c. NAME OF CEMETERY OR CREMATORY James Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Walby		ADDRESS Chestertown, Md	24d. REC'D BY REGISTRAR FEB 1 '60
		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0783

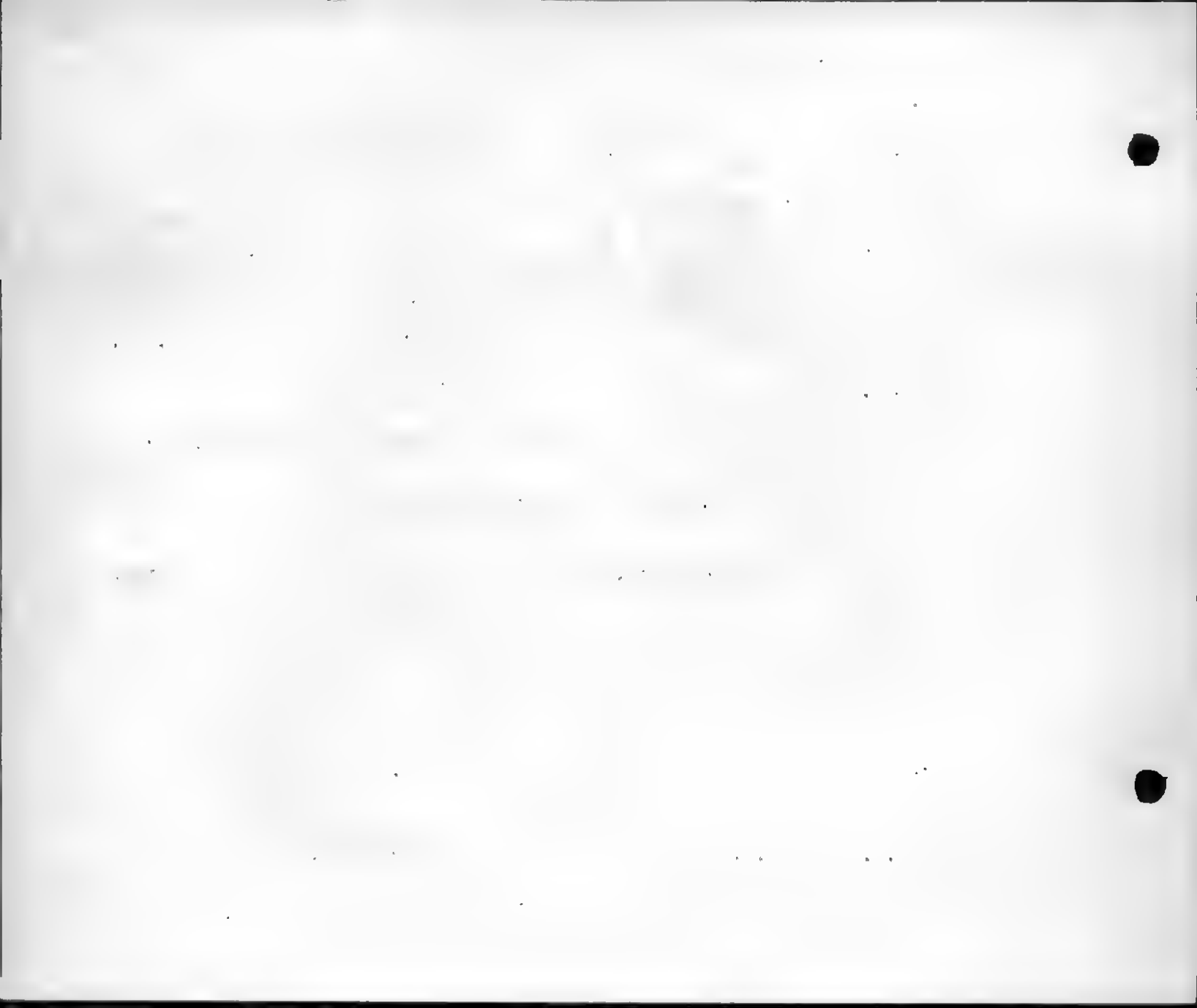
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lily Middle Jarvis Last 5 SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				4. DATE OF DEATH Month January Day 1 Year 19 60			
8. DATE OF BIRTH Jan. 20, 1885				9. AGE (In years last birthday) 74 yrs.			
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William H. Thompson				14. MOTHER'S MAIDEN NAME Emily Jewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 214-32-2102			
17. INFORMANT Hospital records, Chestertown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Coronary insufficiency and strain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 days 1 month years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-12 , 19 59 to 1-1 , 19 60 , that I last saw the deceased alive on 1-1 , 19 60 , and that death occurred at 8:40p. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jan. 2, 1960 DATE SIGNED							
ACTUAL SIGNATURE A.C. Dick, M.D. CHESTERTOWN, MD.							
PHYSICIAN'S NAME (Type) A.C. Dick, M.D. Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 1/4/60							
22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemty							
22d. LOCATION (City, town, or county) (State) Still Pond, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy							
ADDRESS Still Pond, Md.							
24a. REC'D BY REGISTRAR JAN 5 '60							
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0784

CERTIFICATE OF DEATH

Reg. Dist. No.

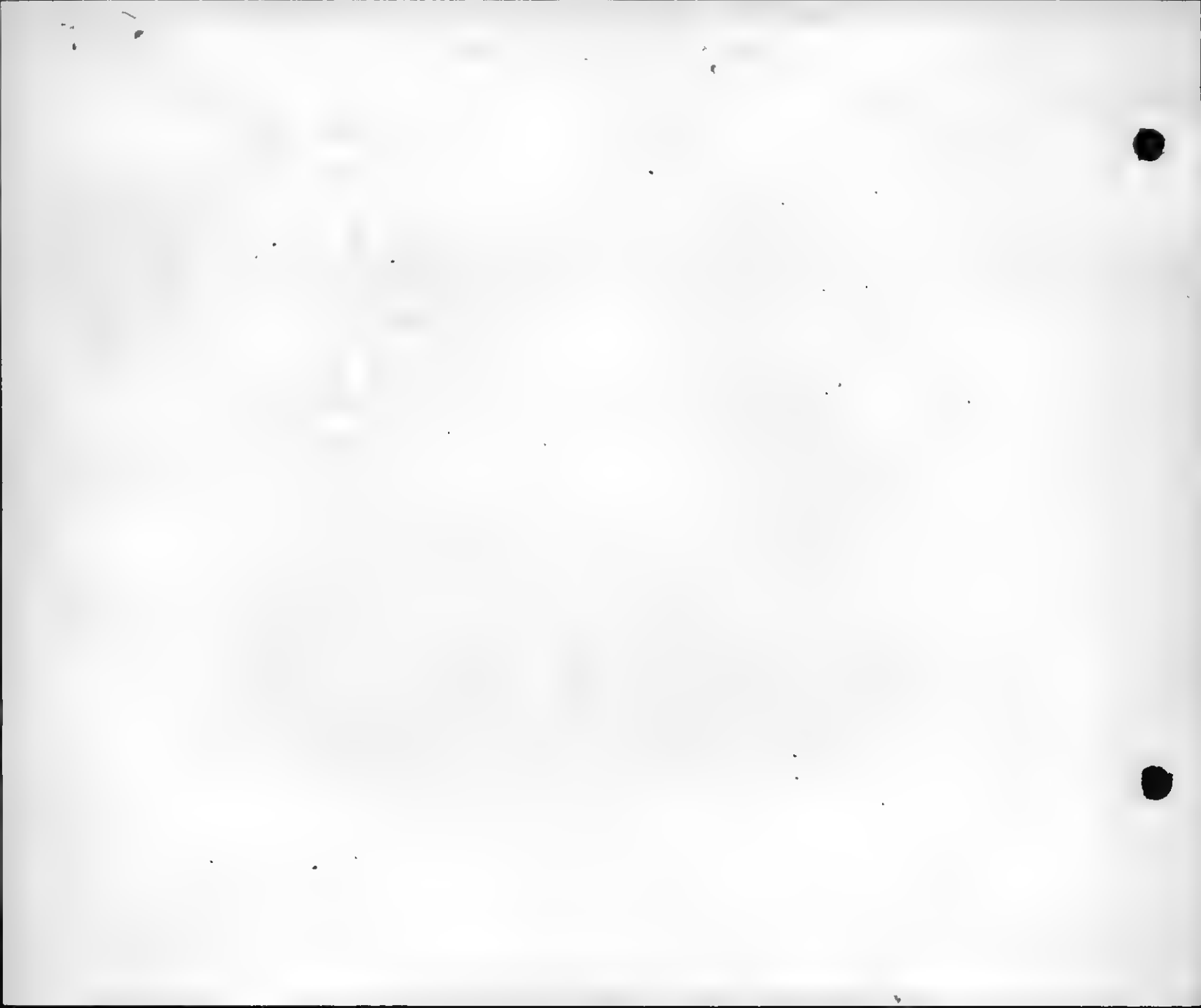
1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CHESTERTOWN c. LENGTH OF STAY IN 1b LIFETIME d. NAME OF HOSPITAL (If not in hospital, give street address) KENT & QUEEN ANNE'S HOSP		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY KENT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) - d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY COVALEE LYNEAR JETER		4. DATE OF DEATH Month JAN Day 31 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 17, 1960	9. AGE (In years last birthday) - yrs.	IF UNDER 1 YEAR Months 14 Days - Hours - Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GORDON ELMER JETER		14. MOTHER'S MAIDEN NAME NETTIE ANN BURKIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		INFORMANT Address HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO - (c) -					INTERVAL BETWEEN ONSET AND DEATH 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, 12 , Year 1960 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1-17-60 to 1-31-60 , that I last saw the deceased alive on 1-31-60 , and that death occurred at 8:15 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) - DATE SIGNED 1-31-60					
ACTUAL SIGNATURE O. S. GULBRANDSEN M.D.					
PHYSICIAN'S NAME (Type) O. S. GULBRANDSEN, M.D. CHESTERTOWN, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/2/60		22c. NAME OF CEMETERY OR CREMATORY CECILTON CEM	
22d. LOCATION (City, town, or county) CECILTON, Cecil Co. MD.		(State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Fellows Millington Md.		24a. REC'D BY REGISTRAR FEB 3 '60		24b. REGISTRAR'S SIGNATURE Caroline S. Hines	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072181XVI



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

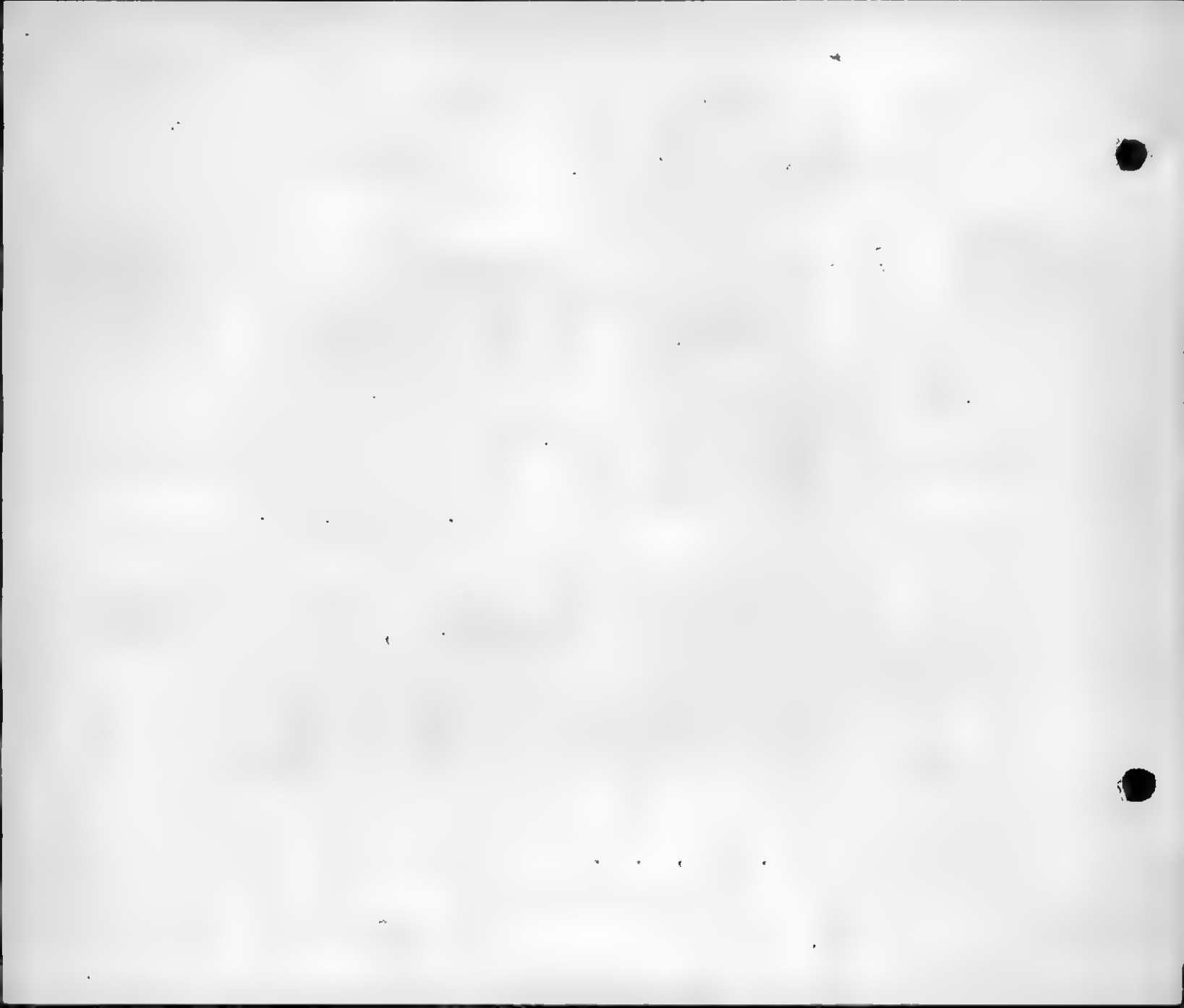
00787

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> <u>0791</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> c. LENGTH OF STAY IN TB <u>5 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admision) a. STATE <u>MARYland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Fred</u> First <u>Lewis</u> Middle <u>Lewis</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>19-60</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/29/82</u> 9. AGE (In years less birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nat Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Grooms</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO <u>XX</u>	
17. INFORMANT <u>Margaret Rock Hall</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Congestive failure</u> DUE TO <u>Arterial Sclerotic Cardio Vascular Disease</u> several years Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic and had had bilateral amputations, lower extremities</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Robert W. Farr, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/8/60</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Batts Neck, Com.</u>		22d. LOCATION (City, town, or county) (State) <u>Shiversville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Robb, Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

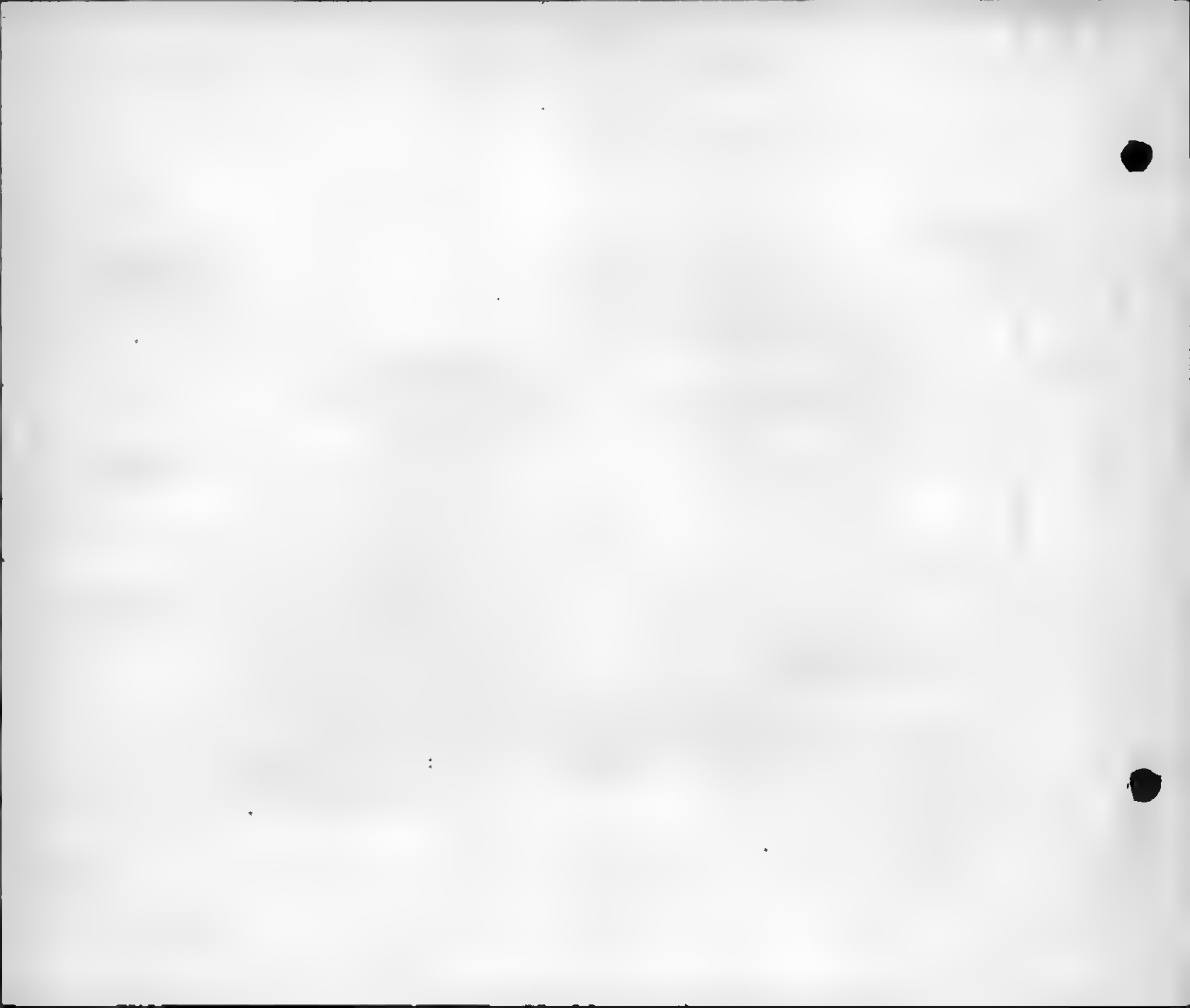
00788

0785

1. PLACE OF DEATH a. COUNTY <u>Mont</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Yrs. 27 Chestertown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chesapeake Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>North Johnson Roger</u>				4. DATE OF DEATH Month Day Year <u>Jan. 17 1960</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5 1904</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dietitian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chesapeake Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Phil.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles J. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Therese M. Webb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>200-26-2171</u>		17. INFORMANT <u>Sara Catherine Meyer Chesapeake Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> Known for 1 month (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>a few minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/25</u> , 1959, to <u>1/17</u> , 1960, that I last saw the deceased alive on <u>1/17</u> , 1960, and that death occurred at <u>8:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown Md.</u> DATE SIGNED <u>19 Jan 1960</u> ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillside Mortuary</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Hillis</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR A MORGUE: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

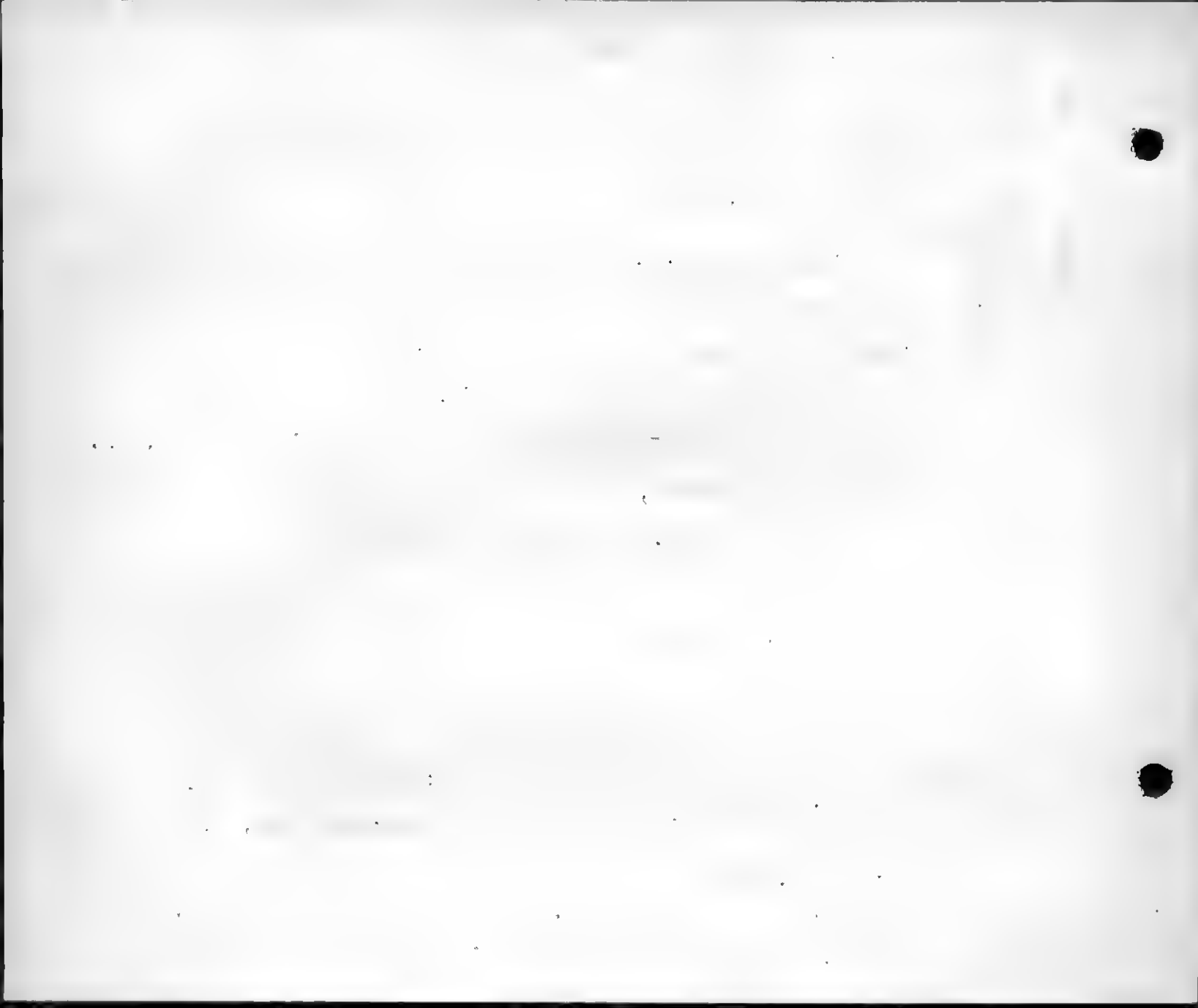


0786 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Chestertown		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Willis William Pickrum		4. DATE OF DEATH Month Day Year January 1 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 May 1899
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook & caretaker		10b. KIND OF BUSINESS OR INDUSTRY YMCA Camp	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Catherine Lamb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 301-09-7905	
17. INFORMANT Hospital Records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stroke, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Probable cerebral thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Extreme obesity, Gangrene of both legs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 December 1959 to 1 January 1960 that I last saw the deceased alive on 1 January 1960 and that death occurred at 3:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Maryland	
PHYSICIAN'S NAME (Type) Robert W. Farr		DATE SIGNED 1/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/6/60	22c. NAME OF CEMETERY OR CREMATORY James Cem.	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hanna		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR AN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0792

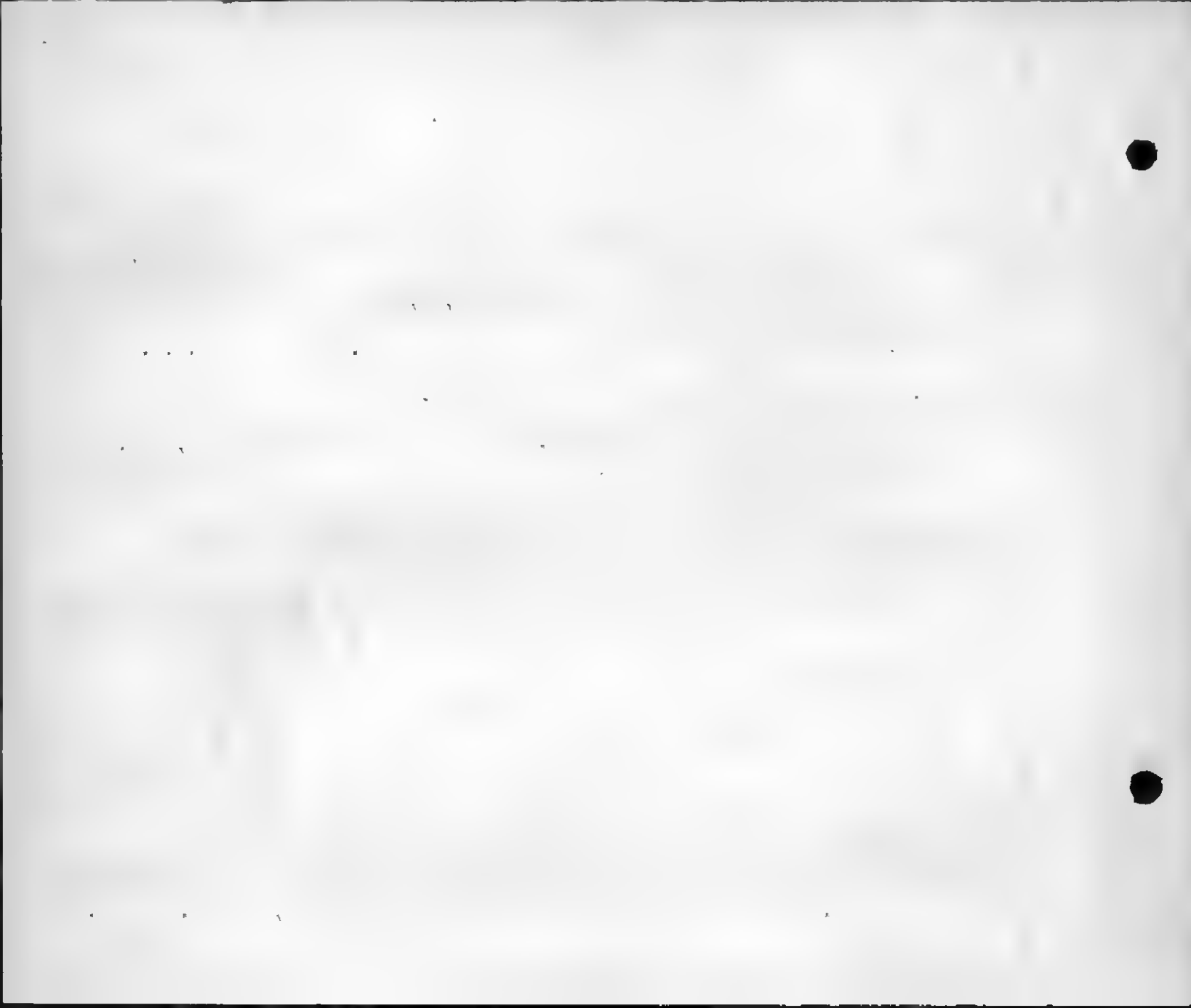
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle RICHARD Last RASIN		4. DATE OF DEATH Month January Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December, 18, 1900
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Still Pond, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Rasin		14. MOTHER'S MAIDEN NAME Jennie M. Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-18-264	
17. INFORMANT Mrs. Bernice Sue Rasin, Millington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 2.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Jan 31 , 19 60 , and that death occurred at 8:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. E. Z. KORALEWSKI		ADDRESS (Street, city or town, state) MILLINGTON MD	
PHYSICIAN'S NAME (Type) G. E. Z. KORALEWSKI		DATE SIGNED 2.1.60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward H. Hous		ADDRESS Millington Md.	
24a. REC'D BY REGISTRAR FEB 3 '60		24b. REGISTRAR'S SIGNATURE Robert S. Hous	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6793

CERTIFICATE OF DEATH

00791

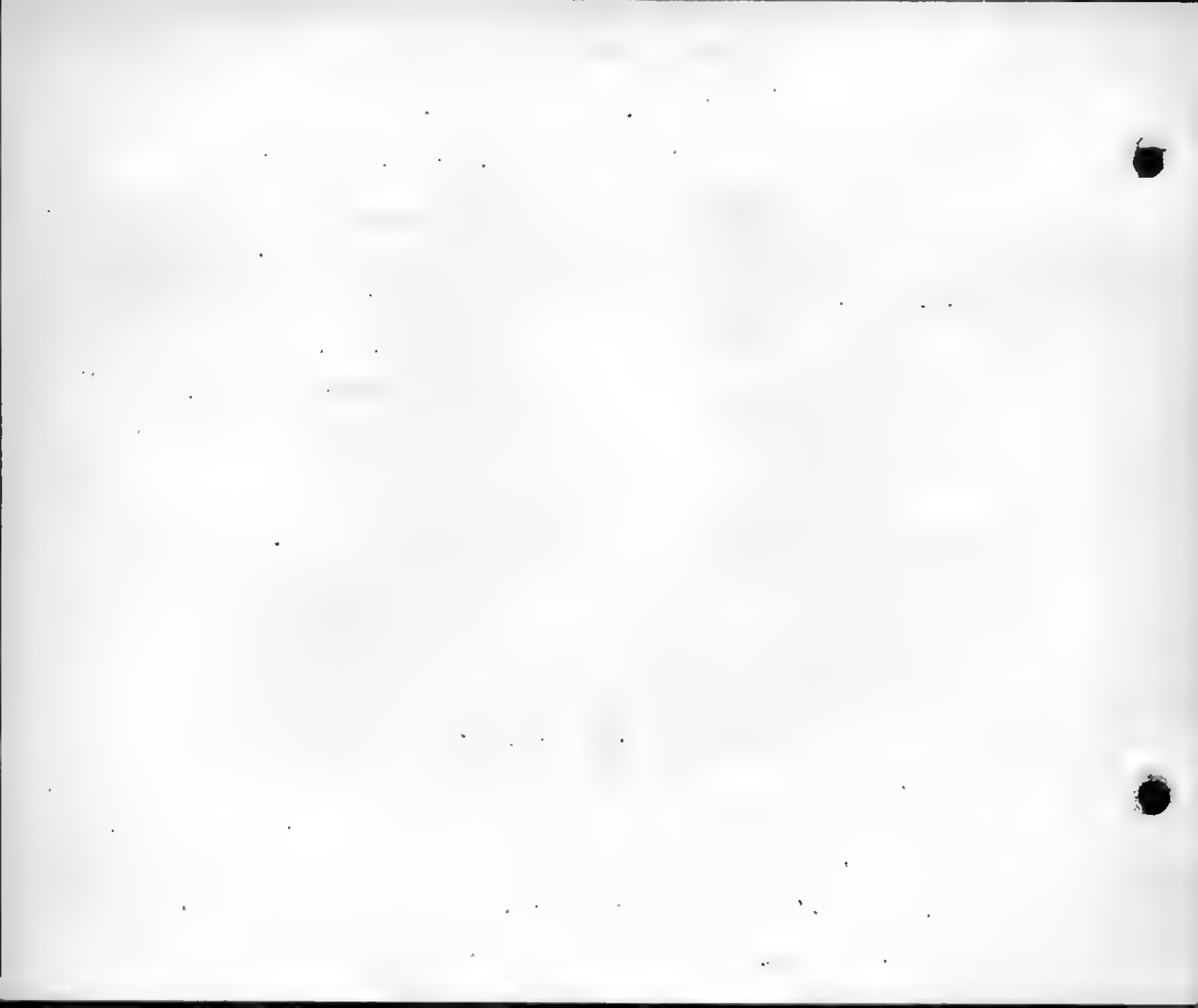
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall Edesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home - Edesville		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Debbie First Middle Last Tilghman		4. DATE OF DEATH Jan. 7 Month Day Year 19 60			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1959		9. AGE (In years last birthday) 7 months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
12. CITIZEN OF WHAT COUNTRY? Usa		13. FATHER'S NAME John Tilghman		14. MOTHER'S MAIDEN NAME Martha Margareta Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		INFORMANT Martha Tilghman Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Deformity of the Larynx DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from May 29, 1959 to Jan 7, 1960 that I last saw the deceased alive on Jan 7, 1960 and that death occurred at Rock Hall, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 1/7/60 ACTUAL SIGNATURE Wm. M. Gatewood M.D. PHYSICIAN'S NAME (Type) Wm. M. Gatewood					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/9/60	22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR JAN 11 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR TO FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072161XV4



0734

CERTIFICATE OF DEATH

00792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROCK HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>EDWARD</u> Middle <u>WATSON</u> Last		4. DATE OF DEATH <u>JAN</u> Month <u>1</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 5, 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATER MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WATSON</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. CLARA BOUTER</u> Address <u>Rock Hall</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Protein Uraculus</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1954</u> to <u>July 1960</u> , that I last saw the deceased alive on <u>Dec 31, 1959</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>NORBERT C. NITSCH</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall MD</u> DATE SIGNED <u>Jan 3/60</u>	
PHYSICIAN'S NAME (Type) <u>NORBERT C. NITSCH</u>		<u>ROCK HALL MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard L. Lane = Church Hill Md.</u> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0782

CERTIFICATE OF DEATH

Reg. Dist. No.

00793

1. PLACE OF DEATH a. COUNTY <u>it</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>K nt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesertown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chesertown</u>				e. STREET ADDRESS <u>111 Chapel Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>William Welch</u>				4. DATE OF DEATH <u>1. 21</u> 19 <u>60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25 1866</u>	9. AGE (In years last birthday) <u>93</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Welch</u>				14. MOTHER'S MAIDEN NAME <u>Harriette St. ples</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Mrs B. J. P. itis</u> Address <u>Chesertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive heart failure</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>5 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10</u> , 19 <u>45</u> , to <u>1-21</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1-21-</u> , 19 <u>60</u> , and that death occurred at <u>11:30a</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chesertown, Md.</u> DATE SIGNED <u>1-21-60</u>							
ACTUAL SIGNATURE <u>A.C. Dick</u>				M. D. <u>Chesertown, Md.</u> <u>1-21-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1 1</u>		22b. DATE THEREOF <u>1/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesertown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chesertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u> ADDRESS <u>Chesertown, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0735 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington		c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ALBERT Last WILSON		4. DATE OF DEATH Month January Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February, 27, 1891
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Wilson		14. MOTHER'S MAIDEN NAME Maggie Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-8175	
17. INFORMANT Wm. Andrew Wilson,		Address Rural Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Carcinoma of the prostate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days years 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 18, 1960 , to Jan 22, 1960 , that I last saw the deceased alive on Jan 21, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE GLEZA KORALEWSKI		ADDRESS (Street, city or town, state) MILLINGTON, MD	
PHYSICIAN'S NAME (Type) GLEZA KORALEWSKI		DATE SIGNED 1.23.60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1960	
22c. NAME OF CEMETERY OR CREMATORY Chesterville Cemetery		22d. LOCATION (City, town, or county) (State) Rural Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		24a. REC'D BY REGISTRAR JAN 27 '60	
ADDRESS Millington, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

01-280MTJAS-WEBIN TO TRANSACT STATE CLOSING

0796 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b X Rural Chestertown, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home near St. Paul's Church		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle M. Last Younger		4. DATE OF DEATH Month Jan. Day 22 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 19	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Hessey	
14. MOTHER'S MAIDEN NAME Elizabeth Ford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Thos. Chadwick Address RD Chestertown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 723.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis - Endarteritis Obliterans DUE TO (c) Arterio Sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from July , 19 59 , to Jan 22 , 1960, that I last saw the deceased alive on Jan 22 , 19 60 , and that death occurred at 3:40 M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Norbert C. Nitsch M.D.		ADDRESS (Street, city or town, state) Rock Hall, Maryland DATE SIGNED 1/23/60	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Jan. 24, 1960 22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem. 22d. LOCATION (City, town, or county) (State) near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 25 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

